Record Release Authorization

I hereby authorize and request on _______________ that you
Today's Date
release copies of my complete medical history in your possession, concerning my illness and / or treatment to:

*Pine Street Family Practice*
*220 East Pine Street*
*Williamstown, NJ 08094*
Telephone 856-629-7436

Patient ____________________________________ Date of Birth _________
Address ________________________________________________________

Signature ____________________________Witness ____________________

Mail this request to your previous doctor:

____________________________________
Doctor

____________________________________
Address

____________________________________

Telephone _____________ Fax ________________

PLEASE FORWARD RECORDS TO OUR OFFICE BY _________
PATIENT IS SCHEDULED FOR AN APPOINTMENT IN OUR OFFICE.

If your office uses a copy service, please fax us the last office note, last well visit note, recent bloodwork and vaccine record to fax 856-875-4742; and have the copy service mail the entire record.
Our providers review all medical records prior to their initial visit in our office.